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MEMORANDUM

TO:
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NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: Dr. Craigan L. Gray
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SUBJECT: Implementation Update #63
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Critical Access Behavioral Health Agency

The Department of Health and Human Services (DHHS) and system stakeholders have been discussing for some time the concept of identifying and recognizing provider agencies who deliver a comprehensive array of services. The DHHS has approved a definition and description of a new category of provider agency, a Critical Access Behavioral Health Agency for mental health and substance abuse services. The requirements for designation as a Critical Access Behavioral Health Agency are attached. Please note that these requirements do not apply to developmental disability services.

Our goals in developing the Critical Access Behavioral Health Agency designation are to:

1. Ensure that critical services are delivered by a clinically competent organization with appropriate medical oversight and the ability to deliver a robust array of services.
2. Move the public system over time to a more coherent service delivery model that reduces clinical fragmentation at the local level and begins to prepare the provider community for the changes that will be required in a waiver environment.
3. Ensure that consumer care is based upon a comprehensive clinical assessment and an appropriate array of services for the population to be served. For example, a provider who will serve only children with mental health issues

might offer outpatient therapy, case management, intensive in-home and day treatment. The array will vary depending upon the age and needs of the consumers to be served by the agency.

Effective January 1, 2010, case management services not included within a "clinical home" service definition will only be delivered through Critical Access Behavioral Health agencies. Once the service definition for Peer Support is approved by the Centers for Medicare and Medicaid Services (CMS), the only agencies allowed to provide that service will be Critical Access Behavioral Health Agencies.

Also effective January 1, 2010, any provider seeking endorsement to provide Intensive In-Home, Day Treatment, or Community Support Team services will have to meet the criteria for designation as a Critical Access Behavioral Health agency; this includes providers who may have started, but not completed, the endorsement process, prior to January 1, 2010. Providers of these three services that are endorsed prior to January 1, 2010, but who do not meet the criteria for designation as a Critical Access Behavioral Health Agency will have until July 1, 2010 to meet those qualifications. Current providers of Intensive In-Home, Day Treatment and Community Support Team that do not achieve certification as a Critical Access Behavioral Health Agency by July 1, 2010 will have their endorsement to provide that service involuntarily withdrawn and will be terminated from the Medicaid program.

Critical Access Behavioral Health Agency status will be certified once for the entire state through a review by a certification team comprised of endorsement staff from Local Management Entities (LMEs) in the region in which the Critical Access Behavioral Health Provider is located and State staff. Included in the certification process will be a demonstration by the agency of its ability to meet the terms of a standardized performance contract developed by DHHS. Included in the contract will be requirements related to geographic areas to be served and requirements prohibiting rejection or premature discharge of consumers served (no eject/reject provisions). The provider will still be required to enter into standardized Memoranda of Agreements (MOAs) with LMEs in the catchment areas in which they deliver services and a standardized contract with those same LMEs for State-funded services. Continued certification as a Critical Access Behavioral Health Agency will be based upon the agency's meeting or exceeding the required performance standards established by DHHS.

Services other than case management and peer support that require endorsement will continue to be endorsed for Critical Access Behavioral Health Agencies on a site/service specific basis. Critical Access Behavioral Health Agencies need not meet the certification criteria in every location in which they deliver case management and peer support services. If a Critical Access Behavioral Health Agency chooses to offer peer support in a location in which they do not meet the certification requirements, they must also deliver case management services in that location.

Providers may experience delays in endorsement activities on a local level over the next several months while LMEs are trained to implement new service definitions and check sheets and learn about this new certification process for the Critical Access Behavioral Health Agency.

We recognize that the implementation of Critical Access Behavioral Health Agency certification represents a significant change for the public mental health, developmental disability, and substance abuse services system, especially at this time of funding reductions and rate cuts. However, we believe that this action is necessary to assure that consumers have access to clinically appropriate and competent services. Additional information on the implementation of these requirements will be coming in the next several weeks.

ValueOptions Webinars

ValueOptions is conducting multiple webinars in the coming weeks to clarify the documents required for the authorization of behavioral health services covered by North Carolina Medicaid, to identify helpful websites and information resources related to the authorization process, and to respond to provider questions. The intended audience is providers who are new to performing clinical home functions such as completing documentation and submitting requests to ValueOptions for review. Specific focus will be on changes related to documentation requirements for Community Support and Level III and Level IV Residential requests discussed in Implementation Updates #60, #61 and #62 available on the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) website: http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/index.

Providers may register for an upcoming webinar by going to http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm and scrolling down to "Provider Training Opportunities" and selecting a date to attend. In addition, providers are encouraged to also register for a webinar to learn how to submit Enhanced Service and Residential requests to ValueOptions electronically via ProviderConnect.

Providers can find instructions for completing an Inpatient Treatment Report (ITR), the ITR template, a link to Person Centered Planning (PCP) training, and a link to a provider training presentation at the same website listed above.

Transition to Psychosocial Rehabilitation Services for Recipients Receiving PSR and Community Support

All Psychosocial Rehabilitation (PSR) service authorizations, for recipients currently receiving PSR and Community Support (CS) services, which are end dated December 31, 2009 or earlier will follow the below process for reauthorization that must occur prior to the date that the current PSR authorization expires.*****

- The PSR provider must work with the CS provider to obtain the current PCP.
- In the event that the PSR provider is unable to obtain the PCP after reasonable efforts, the LME may be contacted to assist in the process.
- PSR providers must submit the ITR and a PCP Update/Revision with appropriate signatures to ValueOptions for the reauthorization request. A service order signature (for medical necessity by an MD/DO, PA, APN, PhD psychologist) is only required if a new service is added to the PCP.
- The maximum authorization may be up to 180 days.
- The PSR qualified professional, in addition to 6 hours of "PCP Thinking," must complete the required 3 hours of "PCP Instructional Elements" training. The PCP Instructional Webcast Training (http://www.ncdhhs.gov/mhddsas/pcp.htm) or other PCP planning/writing training may fulfill this requirement. The qualified professional must be complete this training within sixty (60) days of this IU #63 or within 30 days of hire, whichever comes first.

*** NOTE:** For the following situation, the above process for authorization cannot be used. When the annual re-write of the PCP is due prior to December 31, 2009, a rewritten PCP must be developed with a new service order for medical necessity obtained. The Date of Plan on the Complete PCP is the date on which the annual rewrite of the PCP is due.

All subsequent requests must follow the established authorization procedure outlined in the PCP manual and implementation update #39.

It is our understanding that there are concerns that PSR providers will be responsible to become 'first responders' and also provide transportation and medication management services. As a reminder, PSR providers will be responsible for developing the crisis plan which is a part of PCP development. **PSR providers are not required to be the "first responder."** As a part of the crisis plan, the PSR provider must coordinate with the LME and the recipient to identify local crisis services that can be accessed.

Per the current service definition, it has always been the expectation that PSR providers would arrange psychiatric services as needed. Medicaid does not pay for any Enhanced Service providers to provide transportation. Per the current service definition, it has always been the expectation that PSR provides interventions to help recipients acquire the skills needed to identify and access transportation options in their community.

Community Support with other Enhanced Services

This is a clarification to Implementation Update #60. Authorizations for Medicaid and State-funded Community Support services currently in effect as of the date of this memo will remain valid until the current authorization expires. Therefore, individuals who receive Community Support services with other enhanced services can continue to receive Community Support services, until the current Community Support authorization expires.

Effective October 12, 2009, no new or concurrent requests for Community Support services can be authorized in conjunction with any of the following enhanced services:

- Intensive In-Home Services
- Multisystemic Therapy
- Assertive Community Treatment Team
- Community Support Team
- Substance Abuse Intensive Outpatient Program
- Substance Abuse Comprehensive Outpatient Treatment
- Child and Adolescent Day Treatment
- Psychosocial Rehabilitation
- Opioid Treatment
- SA Medically-Monitored Community Residential Treatment
- SA Non-Medical Community Residential Treatment
- Partial Hospitalization

Requests for Community Support and another enhanced service for children must follow the established Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) procedures and requirements, which are available at http://www.dhhs.state.nc.us/dma/epsdt.

Independent Psychiatric Evaluation for Children Currently in Level III and Level IV

This is a reminder that children currently in Level III and Level IV residential treatment must have an independent (meaning independent of the residential provider and its provider organization) psychiatric evaluation as one of the requirements for concurrent (reauthorization) requests. The psychiatric evaluation must be performed by a psychiatrist, psychiatric physician's assistant (PA) who is working under a psychiatrist's protocol or an Advanced Practice Nurse Practitioner (APN) only. The psychiatric evaluation shall determine the clinical needs of the child and make recommendations for the appropriate level of treatment such as residential, Psychiatric Residential Treatment Facilities (PRTF), or other level of care. Required components of the psychiatric evaluation can be found in Implementation Update #36 under "Comprehensive Clinical Assessment." Please see Implementation Update #60 for all Level III and Level IV reauthorization request requirements. Level III and Level IV providers should be collaborating with the LME and System of Care (SOC) coordinator throughout this process.

Until December 31, 2009, to facilitate implementation of the new requirement for an independent psychiatric evaluation, an interim 30 day authorization may be granted by ValueOptions for situations in which the assessment cannot be completed in time for the reauthorization request. The SOC coordinator must indicate on the discharge plan under his or her signature the date/time of the evaluation as well as the psychiatrist's, PA's, or APN's name. These appointments are subject to verification. This evaluation must be completed within the one month period. This grace period will end on December 31, 2009 and all concurrent requests that are not accompanied by the psychiatric assessment will be returned as, "Unable to Process."

In addition, since September 28, 2009, some providers have had requests returned by ValueOptions as "Unable to Process" because the independent psychiatric evaluation was scheduled but not yet completed, or the psychiatric evaluation was completed but the provider did not yet have a copy of the evaluation. Providers may resubmit these requests to ValueOptions if the independent psychiatric evaluation was completed within 30 days of the authorization request. In these situations, providers may resubmit the original request for reauthorization to ValueOptions and must attach the completed independent psychiatric evaluation. Providers should indicate on the fax cover sheet of the authorization request "Resubmitted with psychiatric evaluation for originally requested Effective Date of <date>."

Authorization Process for New Requests for Level III and Level IV Residential Services

Children admitted to Residential Level III and IV services after September 28, 2009 must follow authorization procedures for new requests as outlined in Implementation Update #60. For these new admissions to child residential services, length of stay is limited to no more than 120 days. An independent psychiatric evaluation does not need to accompany requests for the first 120 days of service, unless clinically indicated. If providers are submitting concurrent (reauthorization) requests for additional treatment after these 120 days, the provider must follow the authorization guidelines for concurrent (reauthorization) requests as outlined in Implementation Update #60 which includes an independent psychiatric evaluation, updated Child and Family Team meeting, and updated Discharge/Transition Plan. Please see full requirements in Implementation Update #60.

Discharge/Transition Plans for Level III & Level IV Residential Services

Discharge/Transition Plans for children in Level III and Level IV Residential services must accompany all requests submitted to ValueOptions. All signatures and dates on the Discharge/Transition Plan must be hand written. The Discharge/Transition plan may be faxed or scanned for submission to ValueOptions.

Psychiatric Residential Treatment Facilities (PRTF) Requirements

As part of the Child Residential Level III and IV stakeholders planning work group, some issues related to rules interpretation for PRTFs were reviewed. PRTF providers indicated that DHHS was interpreting some licensure rules for PRTFs more narrowly than the federal requirements dictated. DHHS has examined the issues and has agreed to the following modifications of current policy:

1. Orders for seclusion and restraint: Only a physician (M.D., D.O.), nurse practitioner, physician's assistant or licensed psychologist may order seclusion and restraint. A RN may issue the written order based upon a verbal authorization from one of the authorized individuals.

2. The required one hour assessment following restraint may be conducted by a physician, nurse practitioner, physician's assistant or RN. Since one purpose of this assessment is to address potential medical issues arising from the restraint, the assessment may not be conducted by a licensed psychologist.

PCP Development and Level II Program – IV Providers

Residential Level II Program – IV providers will be responsible for the development and implementation of the Person Center Plan in instances where a child does not have Community Support services or another clinical home service. Only a qualified professional delivering the residential service may develop the PCP. Level II Program – IV providers may submit authorization requests to ValueOptions if Community Support services are not available. If a child is receiving more than one non-clinical home service, it is expected that the providers will work together during the Child and Family Team meetings to coordinate the Person Centered Plan.

PCP Development and Day Treatment Providers

As stated in Implementation Update #60, Day Treatment providers may be responsible for the development and implementation of the Person Centered Plan, including the crisis plan in instances where a child does not have Community Support services or another clinical home service. Only a qualified professional delivering the Day Treatment service may develop the PCP. As a part of the crisis plan in the PCP, the Day Treatment provider must coordinate with the LME and the recipient to identify local crisis services that can be accessed. If a child is receiving more than one non-clinical home service, it is expected that the providers will work together during the Child and Family Team meetings to coordinate the Person Centered Plan.

Clarification Regarding Timelines for Service Provision of Endorsed Providers

In keeping with the intention of Communication Bulletin #55, providers are expected to be serving consumers within 60 days of enrollment. If a provider has not accepted consumers and began services to consumers within 60 days of DMA direct enrollment, endorsement will be involuntarily withdrawn.

LMEs Billing Medicaid on behalf of Providers

There are certain services for which providers cannot currently directly enroll with the Medicaid program. These include Level II Family Type (therapeutic foster care), Targeted Case Management for DD, and provisionally licensed therapists performing outpatient therapy. DHHS has requested that LMEs bill these services for providers until such time as the providers can directly enroll. Through June 2008, DHHS reimbursed LMEs for performing this billing function on behalf of providers using Mental Health Trust Funds. That funding source has not been available for this purpose for more than a year.

We recognize that this is a time-limited problem that will be corrected when providers can directly enroll with DMA. At that time, providers will be responsible for the cost of billing Medicaid directly for the services they provide, just like all other directly enrolled providers do currently. In the interim, we believe it is appropriate for LMEs to charge providers for performing this function on their behalf. In order to ensure consistency through the system, we have established 15¢ per claim as the allowable billing rate for LMEs to charge for this service.

Provider Verification and Credentialing Activities

As noted in the July 2009 Medicaid Bulletin, the process to re-verify information and credential enrolled Medicaid Community Intervention Services providers is scheduled to begin immediately. Computer Sciences Corporation (CSC) will be notifying providers by mail and sending the notification packet to the provider's billing/accounting address. This will include a pre-printed report of information currently on file with N.C. Medicaid plus a checklist of credentialing-related documents that must be returned to CSC. (Providers may verify their billing/accounting address via the DMA Provider Services NPI and Address Database at http://www.ncdhhs.gov/dma/WebNPI/default.htm or by calling the EVC Call Center at 1-866-844-1113.)

The pre-printed NC MMIS Verification Form includes demographic data and NPI information currently on file with N.C. Medicaid and also contains space for providers to enter license/certification numbers, type of ownership, and contact information. Providers must complete the form, attach copies of documents required for credentialing, and return the verification packet to CSC within 30 days of the date of receipt. The verification process will take up to three weeks from the time CSC receives the correct and complete verification packet from the provider; the return of incomplete or incorrect information may lead to an interruption in enrollment. Lack of compliance in these procedures could result in suspension of enrollment and eventual termination.

Please pay special attention to the designation for Community Support Team. Community Support Team providers are required to submit the verification packet with appropriate credentials including all current Notifications of Endorsement Actions to qualify for enrollment as a provider of Community Support Team services. This will effectively separate Community Support Child (H0036 HA), Community Support Adult (H0036 HB), and Community Support Group (H0036 HQ) from Community Support Team services.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@ncmail.net.

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